

EXHIBIT A
to Answer

Jason Reyes v. City of New York, et al., 07 CV 6349 (PC)

PRISON HEALTH SERVICES
Contracted by NYC Department of Health and Mental Hygiene

CERTIFICATION

I, Cyril Joseph, Assistant Director of Medical Records of Prison Health Services, contracted by NYC Department of Health and Mental Hygiene, hereby certify that the record of the attached is in the custody of, and is an accurate and complete record of the condition, act, transaction, occurrence or event of this program concerning:

REYES, J. K. Y.

(Name of Patient)

4490807611

(Book and Case Number)

I further certify that this record was made in the regular course of business of this program and it is the regular course of business of this program to make such records. The record was made at the time of the condition, act, transaction, occurrence or event recorded or within a reasonable time thereafter.
The record contained herein is a certified reproduction of the record on file (in accordance with CPLR Section 2306)

3/31/08
(Date)

C. Joseph
Cyril Joseph

Assistant Director of Medical Records

DELEGATION OF AUTHORITY

I, PETRINA MARINER, Director of Medical Records of Prison Health Services, contracted by NYC Department of Health and Mental Hygiene, certify that, CYRIL JOSEPH, Assistant Director of Medical Records, of Prison Health Services, contracted by NYC Department of Health and Mental Hygiene, whose signature appears above is a responsible employee of this program. I hereby authorize him to certify records of this program as accurate and complete records of this program, such records having been made in the regular course of business of this program at the time of the condition, act, transaction, occurrence, or event recorded or within a reasonable time thereafter.

P. Mariner
Petrina Mariner.
Director of Medical Records.

[illegible]



DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

INTAKE
HISTORY AND PHYSICAL EXAM

PATIENT'S LAST NAME

Reyes

FIRST NAME

Jason

BOOK & CASE NUMBER

349 06 02628

NYSID NUMBER

0470442Y

DOB

1/13/1983

IS PATIENT EMANCIPATED?

☒ YES ☐ NO

DATE

2.12.2006

TIME

02:53

☒ AM

☐ PM

FACILITY

BBKC

HAVE YOU PREVIOUSLY BEEN INCARCERATED?

☐ YES ☒ NO

If yes, where? ☐ RIKEPS ☐ ELSEWHERE N/A

If yes, when? N/A

DO YOU HAVE MEDICAID OR ANY HEALTH INSURANCE?

☐ YES ☒ NO

WHERE DO YOU CURRENTLY GET MEDICAL CARE?

BETH ISRAEL

1. DO YOU HAVE ANY ALLERGIES?

☐ YES ☒ NO

Reaction Type

☐ HIVES ☐ RASH ☐ SOB

☐ ANAPHYLAXIS ☐ DON'T KNOW

ALLERGIES TO MEDICATIONS?

N/A

OTHER? N/A

2. HAVE YOU EVER HAD CHICKEN POX?

☐ YES ☐ NO ☒ DON'T KNOW

3. HAVE YOU EVER HAD HIGH BLOOD SUGAR OR DIABETES?

☐ YES ☒ NO

yes, Current Medications?

☐ YES ☒ NO

If yes, List on Page 2.

FINGERSTICK

(IN ALCOHOL)

N/A

4. HAVE YOU EVER HAD TB?

☐ YES ☒ NO

Where diagnosed?

N/A

Do you have?

Weight loss ☐ YES ☒ NO

Night Sweats ☐ YES ☒ NO

Fever ☐ YES ☒ NO

Cough > 2 Wks ☐ YES ☒ NO

Chest X-ray done?

☐ YES ☒ NO

If yes, ☐ Normal ☐ Abnormal

When? N/A

Current and Past TB Medications Taken?

N/A

How long taken?

N/A

5. HAVE YOU EVER HAD:

• Multiple Sex partners?

☐ YES ☒ NO

• Unprotected sex?

☐ YES ☒ NO

• Sex with substance abusers?

☐ YES ☒ NO

• Same sex relationship?

☐ YES ☒ NO

• Injection Drug Use?

☐ YES ☒ NO

HAVE YOU EVER HAD:

• Syphilis? ☐ YES ☒ NO

• Gonorrhea? ☐ YES ☒ NO

• Chlamydia? ☐ YES ☒ NO

• Hepatitis A? ☐ YES ☒ NO

• Hepatitis B? ☐ YES ☒ NO

• Hepatitis C? ☐ YES ☒ NO

Any current bc? ☐ YES ☒ NO

Do you have HIV Infection or AIDS?

☐ YES ☒ NO

(If yes, complete HIV Flow Sheet)

6. RAPID HIV TEST

☐ Wants Rapid HIV Test

☒ Declines HIV Testing

☐ Undecided

☐ Confirmatory

☐ Retest

REASONS FOR DECLINING RAPID HIV TEST

☐ Known HIV Positive

☐ Prefer Conventional Test

☐ Had Negative HIV Result < 3 months ago

☒ Not Ready to get test results today

☐ Don't want test now/today

☐ Other

HIV Ab Testing done?

☒ YES ☐ NO

When?

2005

Viral Load

☐ YES ☒ NO

N/A

When? N/A

Latest T-Cell (CD4)

N/A

When? N/A

7. EVER HAD ASTHMA?

☐ YES ☒ NO

If yes, Current Medications?

☐ YES ☒ NO

(List in Page 2)

Last ER Visit? N/A

Last Attack? N/A

Ever Admitted? ☐ YES ☒ NO

Ever Intubated?

☐ YES ☒ NO

When?

N/A

8. EVER HAD A SEIZURE?

☐ YES ☒ NO

If yes, Current Medications?

☐ YES ☒ NO

(List in Page 2)

Last Seizure?

N/A

9. EVER HAD HYPERTENSION?

☐ YES ☒ NO

If yes, Current Medications?

☐ YES ☒ NO

(List in Page 2)

10. DO YOU HAVE:

☐ PUD ☐ SOB

☐ Paresthesia ☐ DDE

☐ Paresthesia ☒ N/A

Chest Pain?

☐ YES ☒ NO

When? N/A

Syncope?

☐ YES ☒ NO

When? N/A

Family history of sudden death under age 55?

☐ YES ☒ NO

Ever had Heart Disease?

☐ YES ☒ NO

Ever had a heart attack?

☐ YES ☒ NO

When? N/A

11. HAVE YOU RECENTLY DELIVERED A BABY?

☐ YES ☒ NO ☐ N/A

• If yes, within the last six (6) weeks? ☐ YES ☒ NO ☐ N/A

• Are you pregnant? ☐ YES ☒ NO ☐ Don't Know ☐ N/A

• Date of last menstrual period? ☐ YES ☒ NO ☐ Don't Know ☐ N/A

12. HAVE YOU HAD A MAMMOGRAM IN THE LAST 12 MONTHS?

☐ YES ☐ NO ☒ N/A

If yes, when? N/A

13. HAVE YOU HAD A PAP SMEAR IN THE LAST 12 MONTHS?

☐ YES ☐ NO ☒ N/A

If yes, when? N/A

14. DO YOU USE DRUGS?

☐ YES ☒ NO

DRUG AMOUNT: N/A

Drugs used: ☐ HEROIN ☐ BARBITURATES ☐ MARIJUANA ☐ CRACK
☐ COCAINE ☐ CRYSTAL METH ☐ METHADONE
☐ OTHER: N/A

If you have answered "YES" to any question and require additional space, please use the Additional Comments area on Page 4.

Page 2 of 4

Reyes, Jason - 149-06-02628

CHS-243 (Rev. 08/06)

15. ARE YOU CURRENTLY IN A METHADONE PROGRAM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		Where? N/A Dose: N/A	16. DO YOU USE ALCOHOL? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO AMOUNT: N/A		Have you considered cutting down drinking? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Annoyed by people asking about your drinking? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Ever had guilty feelings about your drinking? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Ever needed a drink as an "eye opener"? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	When last drink or drug use? N/A
17. DO YOU SMOKE? <input type="checkbox"/> CURRENT <input type="checkbox"/> FORMER <input checked="" type="checkbox"/> NEVER <input type="checkbox"/> NOT ASSESSED		18. HAVE YOU EVER HAD A SCREENING ULTRASOUND OF YOUR ABDOMEN TO LOOK FOR AN ANEURYSM? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DONT KNOW <input checked="" type="checkbox"/> N/A			19. ABDOMINAL ULTRASOUND RESULT? <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> DONT KNOW <input checked="" type="checkbox"/> N/A When? N/A	
20. HISTORY OF DENTAL PROBLEMS (pain, bleeding gums, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, EXPLAIN: N/A				21. HISTORY OF HOSPITALIZATION <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DESCRIBE: INJURY L ANKLE AND HEEL 2002 WITH NERVE DAMAGE BOTH L		
22. ANY ADDITIONAL MEDICAL PROBLEMS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				List PAIN L ANKLE ON PERCOCET PRN		
23. TREATED OR HOSPITALIZED FOR NERVOUS / MENTAL PROBLEMS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO When? N/A		Where? N/A Why? N/A	24. ARE YOU TAKING MEDICATION FOR NERVOUS / MENTAL PROBLEMS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		Medications / Dosage: N/A	
25. HAVE YOU TRIED TO HURT OR KILL YOURSELF? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO When? N/A		How? N/A Why? N/A	26. HAVE YOU EVER BEEN ASSAULTED (SEXUALLY/PHYSICALLY)? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		27. HAVE YOU BEEN CHARGED WITH A VIOLENT ACT (RAPE, ASSAULT)? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO CHARGES REVIEWED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28. HAVE YOU HURT ANYONE WHEN YOU WERE ANGRY OR UPSET? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		When? N/A Who? N/A	How? N/A Why? N/A			
29. FAMILY HISTORY OF MENTAL ILLNESS? If Yes, List Who: N/A <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			30. FAMILY HISTORY OF SUICIDE? If Yes, List Who: N/A <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
31. HAVE YOU EXPERIENCED ANY RECENT LOSSES? (i.e., death, employment, relationships, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			Explain: N/A			
SUMMARY OF CURRENT MEDICATIONS (Please List) N/A						

COMPLETED BY (Print Name) Issa Madhoun

REVIEWED BY: Issa Madhoun

Signature of person completing form

Title

Date

Time


If you have answered "YES" to any question and require additional space, please use the Additional Comments area on Page 4.

Page 2 of 4

2/12/2006 3:43:49 AM

CHS-243 (Rev. 08/06)

NYC 000004

 <p>NYC Health All people have a right to the highest quality of care and services, regardless of race, ethnicity, or sexual orientation.</p>	DIVISION OF HEALTH CARE ACCESS & IMPROVEMENT CORRECTIONAL HEALTH SERVICES			
	Last Name Reyes		First Name Jason	
	Snellen's		Temp 98.8	
	w/o correction R 20 L 20		w correction R N/A L N/A	
				HR 5' 8" Pulse 74 RR 14
VSS Taken by (Full Name) Gladys Paul				Wt 226 Peak Flow
Signature				BP 120 / 70

GENERAL APPEARANCE: (Include body habitus, nutritional status, and state of distress.)

HEENT				Describe				SKIN				Describe							
<input checked="" type="checkbox"/> NL <input type="checkbox"/> Traumatic <input type="checkbox"/> Lacerations <input type="checkbox"/> Other				<input type="checkbox"/> Scalp lesions <input type="checkbox"/> Abnormal Pigment <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Pale sclera <input type="checkbox"/> Other				N/A				<input checked="" type="checkbox"/> NL <input type="checkbox"/> Rash <input type="checkbox"/> Pallor <input type="checkbox"/> Sores				<input type="checkbox"/> Bruises <input type="checkbox"/> Tattoos <input type="checkbox"/> Tracks <input type="checkbox"/> Other			
ORAL CAVITY				Describe				BREASTS				Describe							
<input checked="" type="checkbox"/> NL <input type="checkbox"/> Lesions <input type="checkbox"/> Swellings				<input type="checkbox"/> Filled cavities <input type="checkbox"/> Dentures loose <input type="checkbox"/> Missing teeth <input type="checkbox"/> Other				N/A				<input checked="" type="checkbox"/> NL <input type="checkbox"/> Masses <input type="checkbox"/> Discharge <input type="checkbox"/> Other				N/A			
CHEST				Describe				HEART				Describe							
<input checked="" type="checkbox"/> NL <input type="checkbox"/> Wheezes <input type="checkbox"/> Rales				<input type="checkbox"/> Pubs <input type="checkbox"/> Rhonchi <input type="checkbox"/> Other				N/A				<input checked="" type="checkbox"/> NL /RRR <input type="checkbox"/> Murmur <input type="checkbox"/> Pab				<input type="checkbox"/> Gallop <input type="checkbox"/> Other			
FUNDUS				OTOSCOPIC				LYMPH NODES				NECK THYROID							
<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Not visualized <input type="checkbox"/> Other				<input checked="" type="checkbox"/> NL /Ocular <input type="checkbox"/> NL /TM <input type="checkbox"/> Cerumen <input type="checkbox"/> Abnl				Describe				<input checked="" type="checkbox"/> NL <input type="checkbox"/> Carotid Bruit <input type="checkbox"/> Thyroid enlargement/mass							
ABDOMEN				Describe				GENITALIA				Describe							
<input checked="" type="checkbox"/> NL <input type="checkbox"/> Tenderness <input type="checkbox"/> Hyper/hypactive Bowel sounds <input type="checkbox"/> Organomegaly				<input type="checkbox"/> Asites <input type="checkbox"/> Other				N/A				<input checked="" type="checkbox"/> NL <input type="checkbox"/> Sores <input type="checkbox"/> Discharge <input type="checkbox"/> Lesions <input type="checkbox"/> Warts <input type="checkbox"/> Other				N/A			
PELVIC EXAM (Anus, Uterus)				Describe				PAP SMEAR				Describe							
<input checked="" type="checkbox"/> N/A <input type="checkbox"/> NL <input type="checkbox"/> Discharge from Cervix <input type="checkbox"/> Uterine Mass				<input type="checkbox"/> Rectal <input type="checkbox"/> Abnormal Vitals <input type="checkbox"/> Tenderness <input type="checkbox"/> Other				N/A				<input type="checkbox"/> Performed <input type="checkbox"/> Chlamydia/Gonorrhea Test <input type="checkbox"/> Culture <input type="checkbox"/> Other (Describe)				<input type="checkbox"/> Refused N/A <input type="checkbox"/> Deferred			
RECTAL				Describe				EXTREMITIES				Describe							
<input type="checkbox"/> NL <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Fissures <input type="checkbox"/> Warts				<input type="checkbox"/> Not indicated P/T less than 40 yrs old <input type="checkbox"/> Sores <input checked="" type="checkbox"/> Refused <input type="checkbox"/> Other				N/A				<input type="checkbox"/> NL <input type="checkbox"/> Edema <input type="checkbox"/> Cyanosis				<input type="checkbox"/> Pulse <input type="checkbox"/> Clubbing <input checked="" type="checkbox"/> Other			

MENTAL STATUS

ORIENTATION TO <input checked="" type="checkbox"/> Time <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Person	PSYCHOMOTOR <input checked="" type="checkbox"/> WNL <input type="checkbox"/> Exaggerated <input type="checkbox"/> Agitation	SPEECH <input type="checkbox"/> Coherent <input type="checkbox"/> Incoherent <input type="checkbox"/> Normal Rate <input type="checkbox"/> Precocious <input type="checkbox"/> Spontaneous	MOOD <input checked="" type="checkbox"/> Euthymic <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> Embarrassed/Humiliated	<input type="checkbox"/> Irritable <input type="checkbox"/> Flirted <input type="checkbox"/> Angry	AFFECT <input checked="" type="checkbox"/> Appropriate to mood <input type="checkbox"/> Inappropriate to mood <input type="checkbox"/> Labile	THOUGHT PROCESS <input checked="" type="checkbox"/> Logical <input type="checkbox"/> Illogical <input type="checkbox"/> Relevant <input type="checkbox"/> Irrrelevant	ANY PROBLEMS WITH SLEEP OR APPETITE OR ANY FEELINGS OF HOPELESSNESS OR BEING WORTHLESS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
	SUICIDAL IDEATION? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N/A			HOMICIDAL IDEATION? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N/A				
DELUSIONS <input checked="" type="checkbox"/> None <input type="checkbox"/> Grandiose (Do you have special abilities or features?) <input type="checkbox"/> Persecutory (Do you feel anyone is plotting against you?) <input type="checkbox"/> Somatic <input type="checkbox"/> Other				HALLUCINATIONS Does patient exhibit any? <input checked="" type="checkbox"/> None <input type="checkbox"/> Auditory <input type="checkbox"/> Visual		DOES PT EXHIBIT ANY SIGN OF GROSS MENTAL RETARDATION? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
NEUROLOGIC (Sensory, Motor, DTR, Gait, Cerebellar, Cranial Nerves) SENSORY DEFICIT(S) LHEEL								DESCRIBE (if abnormal, give details in assessment)

If you have answered "YES" to any question and require additional space, please use the Additional Comments area on Page 4.

NYC 000005

[illegible]

REYES, JASON 00000000
 252 50TH ST 3
 NY, NY 11220
 13-JAN-83 O Y M 5'8" 216 BRO BLK
 NY C
 LOPICKELow, ROE
 1866 60TH ST 3, NY, NY FI
 3490602628 0470442Y 11-FEB-06

Patient's Name

Book & Case Number

NYS ID #

Facility

ALLERGIES

DATE LISTED	PROBLEMS	PLAN	DATE RESOLVED
	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
	7.		
	8.		

DATE ORDERED	CLINIC	FACILITY	DATE SEEN	DATE ORDERED/TYPE	DATE PERFORMED	RESULT

SEROLOGY	DATE DONE	RESULT	DATE DONE	RESULT	DATE DONE	RESULT	DATE	TYPE/TREATMENTS
URINE D.S.								
CBC								
ASL/ALT								
SC: (O/G/A)								
Other:								

MMATE HAS CONTRAINDICATIONS FOR:

□ CATEGORY A (CHEMICAL AGENTS)*

Medically contraindicated if the patient has any of the following conditions (check condition)

□ Asthma □ Chronic Obstructive Pulmonary Disease (COPD)

□ CATEGORY B (STUN SHIELD)*

Medically contraindicated if the patient has any of the following conditions (check condition)

□ Pregnancy □ Hypertension □ Pace Maker □ Asthma
 □ Seizure □ Diabetes □ Cardiac disease

□ NONE

PPD

DATE DONE	RESULT	DATE READ	SIGNATURE	IMMUNIZATION	DATE
___/___/___		___/___/___			___/___/___
DATE STARTED	DATE COMPLETED	DATE STOPPED	DATE DOH NOTIFIED	EKG	
___/___/___	___/___/___	___/___/___	___/___/___	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

NYC 000008

Page 1 of 2

Patient chart coming
From C-76

Needs
Wheel Chair

PRE - ADMISSION FORM
Dorm 2B

DATE ACCEPTED: 4/17/06

DATE ARRIVED: _____

TIME ACCEPTED: 12:47 PM

TIME ARRIVED: _____

PATIENT'S NAME: Leyos Jason

B & C # OR DATE OF BIRTH: 3490602628

REFERRING PHYSICIAN: Dr. Hayman

REFERRING FACILITY: Belleue hosp.

REQUESTED ADMISSION DATE: 4/17/06

M.D. OR PHYSICIAN ACCEPTING PATIENT: R. LHM MD

NOTE: THIS PRE-ADMISSION FORM IS VALID FOR 48 HOURS!

DEPARTMENT OF CORRECTION ACTION

CONFIRMED BY: _____
TITLE NAME SHIELD #

COMMAND: _____

DATE: _____ TIME: _____

NOTE: ALL INMATES TO THE INFIRMARY AREAS (DORM 1, 2A, 2B AND 4) MUST HAVE A PRE - ADMISSION FORM. INMATES TO NON - INFIRMARY AREAS (NIC MAIN AND DORM 3) FROM OTHER INSTITUTIONS PRINCIPAL HOSPITAL DOES NOT REQUIRE A PRE - ADMISSION FORM.

Reyes, Jason - 349-06-02628

CHS-283 (Rev. 06/05)

ADDITIONAL COMMENTS (Please include Question Number with each Additional Comments Section)**ASSESSMENT**

S/P LANKLE INJURY 2002 WITH NERVE DAMAGE

PLAN

PAIN MEDS GIVEN CANEF/U PRN

DISPOSITION☐ Medical Isolation Reason
N/A☐ Detox
N/AHOUSING: ☒ GP ☐ CDU
☐ INFIRMARY ☐ C-71 ☐ MO☐ OTHER:CONSULTS: ☐ URGICARE
☐ ER/HOSPITAL ☐ MH EMERGENCY☐ MH ROUTINE ☐ OTHER:**BROCHURES GIVEN?**REACH HIV-STD ☐ YES ☒ NO
Health Information ☒ YES ☐ NO
Dental Brochure ☐ YES ☒ NO**SIGNATURE****DATE/TIME**

2/12/2006 3:41 AM

PRINT NAME

Issa Madhoun

TITLE**REVIEWED BY:** Issa Madhoun**PRINT NAME****SIGNATURE**

2/12/2006 3:41 AM

DATE/TIME

Please use the Additional Comments area on the top of this page for any "YES" question requiring additional space.

PATIENT ACCEPTANCE NOTE
NIC

Dorn EB
 Referring MD/PA Dr. Hayman Date _____
 Referring Facility: Belleview hosp Telephone # _____
 1. Patient: Reyes Jason Date of Birth _____
 Book and Case Number: 3490602B NYSID: _____
 2. Diagnosis / Reason for Infirmity Care: Dysphagia Reflex Sympathetic
 3. History of Illness (use other side if more room needed): _____
 4. Other considerations: Date of last fever: _____
 Abnormal mental status? D
 Ambulation status? Wheelchair bound Incontinence? _____
 Nursing needs? (dressings, catheters, feeding, turning, etc.) D
 5. Labs: PPD & Date: _____ CXR & Date: _____
 Special (CT's, LP's, etc.) _____
 Pertinent blood results _____
 6. Medications (doses, frequency, when to stop): _____
 7. Follow-up needed: D INH / Date? _____
 8. If MH/Nursing / Chief MD approval needed*, who contacted / when? _____
 9. Accepted by: Dr. LHM (MD / PA) Date: 4/17/06
 * If high level nursing care needed, contact CNA, PCC or nurse in charge; if psychiatric disturbance, contact Mental Health



NYC HEALTH AND HOSPITAL CORPORATION
CORRECTIONAL HEALTH SERVICES

INFIRMARY ADMISSION HISTORY AND ASSESSMENT

SECTION I		INFIRMARY <u>Nic DDA</u> NAME <u>Reyes, Jason</u> DOB <u>349 06 03638</u> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		ADMITTING DATA ADMITTING NURSE <u>B Jackson</u> INTERPRETER <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO LANGUAGE USED RELIGION <u>English</u>	
REFERRAL SOURCE <u>Grac Bellevue</u> MEDICAL DIAGNOSIS <u>Reflex Sympathetic Dystrophy</u> PRESENT HEALTH HISTORY PAST HEALTH HISTORY		PREVIOUS HOSPITALIZATION: <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES (SPECIFY) _____ ADDICTIVE HABITS: TOBACCO: <input type="checkbox"/> NO <input type="checkbox"/> YES # PACKS/DAY X # YEARS _____ ILICIT DRUGS: <input type="checkbox"/> NO <input type="checkbox"/> YES (SPECIFY) _____ ALLERGIES: <input type="checkbox"/> NONE KNOWN <input type="checkbox"/> YES (SPECIFY) _____ SPEECH: <input type="checkbox"/> SLURRED <input type="checkbox"/> APHASIA <input checked="" type="checkbox"/> PROBLEM <input type="checkbox"/> OTHER _____ VISION: <input checked="" type="checkbox"/> NO PROBLEM <input type="checkbox"/> IMPAIRED <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> GLASSES <input type="checkbox"/> CONTACT LENSES <input type="checkbox"/> ARTIFICIAL EYE <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> HEARING AID <input type="checkbox"/> RT <input type="checkbox"/> LT DENTURES: <input type="checkbox"/> UPPER <input type="checkbox"/> LOWER <input type="checkbox"/> PARTIAL <input type="checkbox"/> NONE <input type="checkbox"/> DIET: _____ ACTIVITY STATUS: <input type="checkbox"/> AMBULATORY <input type="checkbox"/> AMBULATORY WITH ASSIST <input type="checkbox"/> TRANSFER WITH ASSIST <input type="checkbox"/> BED REST ASSISTIVE DEVICES: <input type="checkbox"/> CANE <input checked="" type="checkbox"/> WHEELCHAIR <input type="checkbox"/> WALKER <input type="checkbox"/> CRUTCHES <input type="checkbox"/> PROSTHESIS _____ <input type="checkbox"/> NONE <input type="checkbox"/> OTHER _____			
ADVANCE DIRECTIVES: <input type="checkbox"/> NONE <input type="checkbox"/> YES (SPECIFY) _____ MEDICATION		SELF CARE STATUS: INDEPENDENT <input checked="" type="checkbox"/> ASSIST <input type="checkbox"/> DEPENDENT FEEDING <input checked="" type="checkbox"/> BATHING <input checked="" type="checkbox"/> GROOMING <input checked="" type="checkbox"/> DRESSING <input checked="" type="checkbox"/> TOILETING <input checked="" type="checkbox"/> INCONTINENT <input type="checkbox"/> NO <input type="checkbox"/> YES (SPECIFY) _____ FLUIDS: _____ METHADONE MAINTENANCE PROGRAM <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES			
DRUG DOSE FREQ LAST DOSE TAKEN REASON DATE		IMMUNIZATION DATE VITAL SIGNS TEMP PULSE BP HEIGHT WEIGHT VISUAL SCREEN Nurse's Signature/Time			
TB-DRUG THERAPY START DATE COMPLETE DATE STOP DATE DOH NOTIFIED DATE CAR					

NYC 0000012

[illegible]

RESPIRATORY: ☐ cough ☐ sputum ☐ no ☒ yes describe _____
☐ dyspnea ☐ orthopnea ☐ cyanosis ☒ none

COMMENTS:

CARDIOVASCULAR: ☐ chest pain ☐ palpitations ☐ varicosities: _____
☐ poor circulation to extremities ☐ edema: _____

COMMENTS:

GASTROINTESTINAL: ☐ nausea ☐ vomiting ☐ anorexia ☐ dysphagia ☐ bleeding
☐ hemorrhoids ☐ weight loss ☐ weight gain ☐ diarrhea
☐ constipation: _____ ☐ freq. of BM: _____ ☐ ostomy: _____

COMMENTS:

GENTIO-URINARY: ☐ dysuria ☐ hematuria ☐ retention ☐ nocturia ☐ frequency
☐ ostomy: _____ ☐ catheter: _____ ☐ dialysis: _____

COMMENTS:

MALE: ☐ prostate enlargement ☐ urethral/penile discharge ☐ no ☐ yes (specify) _____
☐ lesions ☐ no ☐ yes **STD:** ☐ no ☐ yes (specify): _____

COMMENTS:

FEMALE: LMP: W/18 pregnant ☐ no ☐ yes pregnancies: _____ miscarriages: _____
abortions: _____ live births: _____ birth control: ☐ no ☐ yes:
pelvic/uterine infection: ☐ no ☐ yes vaginal discharge: ☐ no ☐ yes:
lesions: ☐ no ☐ yes **STD:** ☐ no ☐ yes (specify): _____

COMMENTS:

BREAST: masses: ☐ no ☐ yes discharge: ☐ no ☐ yes: _____ BSE: ☐ no ☐ yes

COMMENTS:

MUSCLO-SKELETAL: ☐ arthritis ☐ paralysis: _____ ☐ paresis: _____ ☐ amputation: _____
☐ contractures: _____ ☐ deformity: _____ ☐ fracture: _____

COMMENTS:

NEUROLOGICAL: headaches: _____ vertigo _____ syncope _____ tremors _____ seizures: _____
sensory/motor impairment: _____ orientated person place time

COMMENTS:

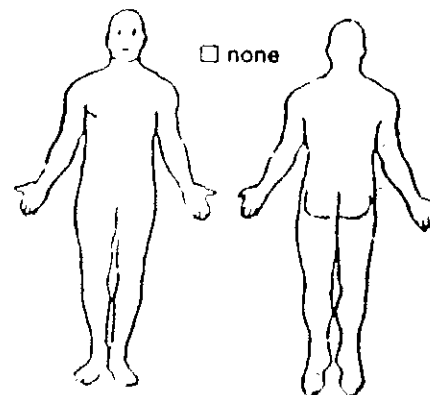
PAIN: location: _____ type: _____ onset: _____ duration: _____ ☐ none

SKIN: temperature: ☐ warm ☐ cold ☐ moist ☒ dry ☐ turgor: ☒ good ☐ poor
hair: _____ nails: _____

COMMENTS:

Identify on diagram site of the following:

A = bruises, B = masses, C = scars, D = lesions, F = wounds
and D = decubitus (describe size, shape, stage)



EDUCATIONAL NEEDS:

DISCHARGE PLANNING:

WHERE WILL YOU GO WHEN DISCHARGED: _____

ANYONE TO ASSIST YOU AFTER DISCHARGE: _____

PLAN OF CARE:

STARTED

☒ YES

☐ NO

EXPLAIN: _____

ORIENTATION TO ENVIRONMENT:

☒ YES

☐ NO

EXPLAIN: _____

SIGNATURE/TITLE OF DATA COLLECTOR:

RN REVIEWER:

DATE: 4/17/06 TIME: _____

DEPARTMENT OF NURSING
 INFIRMARY CLINICAL ACTIVITY FLOWSHEET

PATIENT'S NAME REYES JASON
 ID# 349-06-02628
 AGE/D.O.B. _____ SEX: ☒ M ☐ F
 AREA: NIC D. 2A

DATE		TIME		T		E		M		P		E		R		A		T		U		R		E	
4-18-06		10/19		10/19		10/19		10/19		10/19		10/19		10/19		10/19		10/19		10/19		10/19		10/19	
104°		104°		104°		104°		104°		104°		104°		104°		104°		104°		104°		104°		104°	
103°		103°		103°		103°		103°		103°		103°		103°		103°		103°		103°		103°		103°	
102°		102°		102°		102°		102°		102°		102°		102°		102°		102°		102°		102°		102°	
101°		101°		101°		101°		101°		101°		101°		101°		101°		101°		101°		101°		101°	
100°		100°		100°		100°		100°		100°		100°		100°		100°		100°		100°		100°		100°	
99°		99°		99°		99°		99°		99°		99°		99°		99°		99°		99°		99°		99°	
98°		98°		98°		98°		98°		98°		98°		98°		98°		98°		98°		98°		98°	
97°		97°		97°		97°		97°		97°		97°		97°		97°		97°		97°		97°		97°	
96°		96°		96°		96°		96°		96°		96°		96°		96°		96°		96°		96°		96°	
PULSE		84		88		96		82		72		82		84		82		68		68		68		68	
RESPIRATION		18		18		16		18		14		82		84		82		68		68		68		68	
BLOOD PRESSURE		110/80		110/80		100/80		120/90		120/90		20/120		16/120		16/120		16/120		16/120		16/120		16/120	
WEIGHT		160		160		160		160		160		160		160		160		160		160		160		160	
N/A INITIALS		R		R		R		R		R		R		R		R		R		R		R		R	
F L U I D S		INTAKE C.C.		ORAL OTHER TOTAL		OUTPUT C.C.		URINE OTHER TOTAL																	
TIME		R		E		S		U		L		A		R											
DIET TYPE		R		E		S		U		L		A		R											
CONSUMED:		ALL		1/2		1/4		NONE																	
SUP. FEEDING																									
NG FEEDINGS																									
Q _____ HR.																									
M S T A T U S		ALERT		ORIENTED		OTHER																			
S A F E T Y		SIDE RAILS		= UP		= DOWN																			

⊙ = ABNORMAL FINDINGS, (R) = REFUSED AND O = OUT TO COURT MUST BE CIRCLED IN RED
 ✓ = NO CHANGE / DONE
 * = SEE PROGRESS NOTES
 BLANK = NOT APPLICABLE

DATE:		PRIMARY CLINICAL ACTIVITY FLOWSHEET						
TIME:		4/18	4/19/08	4/20/08	4/21/08	4/22/08	4/23	4/24
ISOLATION:								
RESPIRATORY								
ENTERIC								
OTHER								
SELF CARE	BATH							
	COMPLETE:							
	PARTIAL							
	SELF							
	MOUTH CARE							
FOLEY / PERI								
FOOT CARE								
ACTIVITY	BEDREST							
	TURNED &							
	POSITION							
	DANGLE							
	COMMODE							
	BED / CHAIR							
	BRP							
	AMBULATE							
	W / ASSIST							
	AMBULATORY							
ELIMINATION:								
CONTINENT								
INCONTINENT								
FOLEY								
SUPRA PUBIC								
CATHA								
B.M.								
OTHER								
SLEEP	SATIS - FACTORY							
	UNSATIS - FACTORY							
THERAPY	PHYSICAL THERAPY							
	PENTAMADINE							
	SPUTUM							
I.V. LINES:								
TYPE AND SITE:								
DRESSING CHANGE								
Q								
TUBING INITIALS								
Q								
NURSE INITIALS								
INITIALS	SIGNATURE		INITIALS	SIGNATURE		INITIALS	SIGNATURE	
	Pauline Toborn, NA			Richardson				
	Lp & Lw Anger							

Form 1110-1-7

NYC 0000017



DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

Reyes Jason

3490602628

DOB 1/13/83

OBSERVATIONS

No chest

2/17/06

Flu old LT ankle injury

BBK

sl 22yW p⁺ E h/o LT ankle neurological
damage sl 2002 trauma presents
stating minimal pain relief E 90°
Motion

MHW

9:15 AM

OT B16 P70 ambulates E cane + limp
LT ankle - atrophy, ROM, scars
sl old LT ankle injury E motion
Limitation 2 yrs

Pl - Naproxen 1 Tylenol
educated on meds

sl - 8/11 pm
Consider adding Tylenol #3
if no relief

Jacques Lorths, RPAAC

Revised 1/1/06



DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

Reyes Jaden
3490602628

DVB 1/13/83

DATE	OBSERVATIONS
2/13/06 13m	I- Request Note for cane O- H/O Anterior injury S/p Note for cane given to pt FLC in 3 weeks in sick w FLC
2/14/06 10p	Medical note re: all is Aspxoxal / Tylenol renewed - Orders expired - few days ago Orders written for 5 days ntc pm Franklin Mejia, MD
BRUC 3/20/06 Mei 857m	S/C S/ 2246 of E old LT ankle injury E subsequent sensory/motor dysfun. pt requesting renewal of cane OI R14 978 LT handle - drom, of ulcers, vascular intact At 2246 of E old injury LT ankle motor dysfun P/ DOC (with cane permit flw s/c pm reval. s/p 30045 Jacques Centre Jr, RPAI Cristian Pedestru, MD



DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

Keyes Jason
3490602628
1/13/83

DATE	OBSERVATIONS
3/28/06	S/C
BIBU Mini 600PM	<p>SI 23 y/o ♂ E H/O RSD presents w pain management regimen provided by his PMD Dr Germaine N. Rowe M.D. Referred on 3/20/06. Pt currently w ch T pain intensity of R/L PDD ambulates slowly & a cane at skull ♂ E H/O RSD to left lower extremity. Pl-FU clinic 3/29/06 for md pain meds review & evaluation - Copy of pt letter will be made</p>
	LANDIS BARNES, U.O.



DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

Payes, Jason
349-06-02628
BBKey

DATE

OBSERVATIONS

Redacted

3/30/06 - S/P (D Ankle injury: Ambulate c cane -
c/p pain -
GAT - See previous notes
P Naproxen 500mg BID x 5D
Robaxin 500mg BID x 7D
F/U PRN.

Celia Tindale, RPA

Franklin Mejia, MD



DIVISION OF HEALTH CARE ACCESS AND
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND:

REYES, JASON 00000000
252 50TH ST 3
NY, NY 11220
13-JAN-83 O Y M 5'8" 216 BRO BLK
NY C
LOPICKELow, ROE FI
1866 60TH ST 3, NY, NY
3490602628 0470442Y 11-FEB-06

DATE	OBSERVATIONS
4/12/06 EmTC 8:15p	S- Pt seen in clinic for S/Call - C/O difficulty in ambulation. State "I have this problem for 4 yrs." C - TPR 99.8 88.18 B/P: 128/74. Pt able to stand up w/ assist. Significant ambulating. Muscle twitching noted. A - Unsteady gait. Difficulty ambulating. P - Referred to me for further eval. - Ullrich RN
4/13/06 C76 8:45p	S/P @ ankle injury (4y). Patient ambulating w/ severe difficulty even w/ walking cane help. Has been able to stand but w/ assistance VS stable Hx of RSD (reflex sympathetic dystrophy). See above VS. ATTEMPT TO TRANSFER PATIENT TO NIC: NO BED AVAILABLE AS PER B. SINGA. Patient gives catches to help in ambulating. P/C card given for F.V. in Apr (4/14/06). - D. J. A. S. A. L. -



DIVISION OF HEALTH CARE ACCESS AND IMP
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

REYES, JASON 000000000
252 50TH ST 3
NY, NY 11220
13-JAN-83 O Y M 5'8" 216 BRO BLK
NY C
LOPICKELow, ROE FI
1866 60TH ST 3, NY, NY
3490602628 0470442Y 11-FEB-06

DATE	OBSERVATIONS
4/14/06	Flu
EMT 1M	Ordered by SMD to transfer P to NYC
11:45 AM	Took documentation from P's MD
	the RSD (Reflex Sympathetic Dystrophy also known as Complex Regional Pain Syndrome
	P remained in NYC last night - denied admission to beds.
	P housed on main floor and given central but still many problems ambulating. Also weakly as last making it difficult to do ADL's
OTAGS	8013d78 P72 R2 16
	P ambulates & crutches but needs assistance getting up from the chair
	① RSD (Reflex Sympathetic Dystrophy
	② Call to NYC - Spoke to Dr. Georges - states not a candidate also states there are no beds
	SMD made aware
	Flu 4-2 start to reach NYC
4/14/06	Multiple attempts made to follow up SMD or administrator of NYC failed Dr. Colichman was informed about the problem and also about the need for NYC bed.
	Case will be endorsed to the 4-12 MD for Down-3 admission

Glenda Shearn, PA

Jean Lautaud, MD



PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

DATE	OBSERVATIONS
4/14/06 CT6 982	Patient transfer to room 3 for medical reasons NO BED IN NIC - DOC NOTIFIED Gabriel Jean Louis, MD
4/19/06	M.O.N.N. c/o pain Return to room start 7:00 PM and A.M.
4/21/06 NIC D 3 11 AM	s/c pt c/o pain in @ foot. pt on pain medication and will wait pain management to follow-up. w/s - stable @ foot @ day swelling @ redness NI pulse bilab A/p - s/p @ foot injury cont. current management Neurology HU Harjinder Bhatti, MD Youness Sowah, RPA



DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

REYES, JASON
3410602628

DATE	OBSERVATIONS
5/12/06	SC 1 PM
NIC 03	PT NOTE
1245	QUESTION ON MEDICATIONS C/O CONSTIPATION
	23 Y.O. PMH: REFLEX SYMPATHETIC DYSTROPHY
	2° TRAUMA (L) ILEAL 4/16/04 LUTHERAN HOSP
	SYMPS BSO DEPRESSION WITHIN 3 to 4 WEEKS
	PAN (L) LEGS NUMBS (R) HIT
	WHEEL CHAIR SINCE 4/17/06
	GAIN + WEAKNESS TO LEGS
	FOLLOWUP AT PT INSURANCE STATISTICS
	OK AT LUTHERAN HOSP APPROX 1502 OR 1505
	9 T 95° P 72 R 14 P 72
	MECH SUPPLY
	NO CERVICAL NOISE
	PHARYNX CLEAR TM CLEAR
	PERIA PAIN NORMAL
	HEENT AB 5 M
	UNUS CTA
	ABO AS NORMAL soft nose / no lgr
	SLIGHT DECREASE S 2 R ILI CALC VS R1
	TRACHE CUFFY F55
	CA 242 LIVER
	CA 242 LIVER HYPOPARATHYROIDISM
	MEDIA 1152 S 2 R HYPERPARATHYROIDISM

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

CHS 298 (Rev J/05)

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

DATE _____

OBSERVATIONS

5/18/06

Nico

dorm.

12.30 AM

06
0 S pt stated for PSTPR, how-
ever pt declines services. PT
reported he spoke to MH 2 to
anger as he was not getting
the proper pain medication. PT
reported he is now getting his oxy-
Contin 20mg q. Thus, he re-
ported he is no longer stressed. Denies
any depression/anxiety, pt does
not exhibit any symptoms of the
above. pt denies any past Yhx.
pt did report that talking w MH
helped as he was frustrated. Medical
was not giving him proper Meds. A letter
from community confirmed his pain
meds. Thus, pt not in distress and not
in need of MH Fll.

[REDACTED]

pt stable in dorm 3 w/ no MH F/U.
pt is aware how to access MH services
if needed.
P. GP dorm 3 NO MH F/U.

Frederick Guy